MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Wol + Med, Ed. Wolski, M.D. 24361 35 East South, Ste. 336 Denton TX 75205	MDR Tracking No.: M4-03-7194-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 12 TASB Risk Mgmt. Fund PO Box 2719 Austin TX 78752	Date of Injury: Employer's Name: Denton ISD Insurance Carrier's No.: 0251341012550073

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
5/27/02	5/27/02	97139-PH	$56.00	$56.00
12/9/02	12/9/02	99213	$9.60	$0.00
2/10/03	2/10/03	99213	9.60	$0.00
2/10/03	2/10/03	99080 (73)	3.00	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

5/21/03, TWCC 60 Table of Disputed Services:

" The Table of Disputed Service, under the title Requestor's rationale, "PEC M & O 133.304(i) When the insurance carrier pays a health care provider for treatment(s) and/or services for which the Commission has not established MAR, the insurance carrier shall: (1) develop and consistently apply…fair and reasonable reimbursement to ensure that similar procedures…(2) explain and document…apply consistently…"

6/24/03 letter: "For DOS 5/27/02, cod 97139 PH …There is no MAR for this code, but the carrier failed to pay us for two units…We feel the carrier has failed to comply with Rule 133.1(8)…" (A) the MAR, when one has been established in an applicable Commission fee guideline, (B) the determination of a payment amount for medical treatment(s) and/or service(s) for which the Commission has established no MAR amount…"

" *Justification For Fees For Service:* This healthcare provider has taken the following factors into consideration for the purpose of determining his (their) usual and customary fees for services rendered….1) time and labor…difficulty…skill required..2)…likelihood that the time…3) the professional fee…charged in locality for similar…services 4) time limitations… 5) nature and length of professional relationship…6) the experience, reputation and ability…"

PART IV: RESPONDENT'S POSITION SUMMARY

7/23/03: "…The Wol+Med…billed TASB for …office visits…and work status report…The reductions in payment were made based on what appears to have been a negotiated contract. Additional review…shows that the contract rate was applied in error. Consequently, TASB agrees to remit additional reimbursement in the amount of $9.60 for each office visit…and $3.00 for the work status report. The additional reimbursements brings the payments up to the MAR…per the 1996 MFG…The requestor billed…$50.00 per unit for phonophoresis using CPT code 97139-PH on DOS 5/27/02…reimbursed…$22.00 per unit…

"Note: The Commission has issued an Advisory (2003-09) stating, in part, "…The Commission will appeal this decision… (to grant permanent injunction pertaining to 133.304(i) to the Third Court of Appeals in Austin. After consultation with the Office of the Attorney General, it is our understanding that, until all avenues for further judicial review and appealed are exhausted by the Commission, this decision is superceded and thus, Rule 133.304 (i) remains fully in effect…" So, for the purpose of resolving this dispute, the standard of fair and reasonable does apply to the requestor and Commission Rule 133.304(i) remains in effect…

Payment Methodology: The requestor billed TASB $50.00 per unit for…97139-ph…TASB reimbursed the requestor $22.00 per unit using the relative value unit of 3.00 listed for PCT Code 97139 in the 8/1/91 MFG, then applied the conversion factor of $6.75 which yielded…$20.25. Next, TASB rounded the converted reimbursement to the nearest whole dollar then added 10%, for a result of $22.00….The requestor failed to prove that its billing of usual and customary is fair and reasonable…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

CPT code 97139-PH on DOS 5/27/02 was denied "M – fair and reasonable reimbursement."

- The requestor submitted convincing evidence to support usual and customary charges according to 133.1 (a)(8) therefore, additional reimbursement is recommended.
- Amount due: $100.00 less amount paid -$44.00 = $56.00

CPT codes 99213 and 99080.73 for DOS 12/9/02 and 2/10/03 were reconsidered by the respondent and reimbursement per MAR was made on/or about 7/23/03, therefore, a dispute no longer exists.

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $56.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

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Ordered by:

Authorized Signature	Typed Name	Date of Order
		04/13/05

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, 7551 Metro Center Drive, Suite #100, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____